DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING _____ B. WING _____	C 10/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING CENTER	31 DERICKSON LANE STANTON, KY 40380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY15362) was conducted on October 28-29, 2010. Deficient practice was identified at 'G' level, with an opportunity to correct.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that one (1) of four (4) sampled residents (resident #1) received adequate supervision and assistive devices to prevent accidents. Resident #1 was admitted to the facility on September 11, 2010, with a known history of falls with injury. On September 12, 2010, at 2:00 a.m., resident #1 was placed at the nurses' station and a sounding alarm applied to the resident's chair due to repeated attempts to get out of the bed/chair unassisted and increased agitation. However, staff left the resident unattended, out of visual sight and auditory range, and the resident was found lying on the floor with a laceration to the back of the head and a fractured right hip. The findings include:	F 323	F323 1. Resident #1 was sent to the hospital and discharged from our center. 2. An audit of all current care plans will be completed by Director of Nursing, Unit Managers and/or Regional Director of Clinical Services and/or Facility Rehab Coordinator by November 30,2010 to identify if fall prevention interventions are appropriate and individualized for all current residents, along with staff and family interviews for any additional needed information related to falls. 3. Beginning November 15, 2010 new admissions will be reviewed in Morning Meeting(conducted by the Administrator and consists of DON, UM, Facility Rehab Coordinator, Social Services and Life Enrichment Director) to identify fall risk and implement an initial individualized plan of care to meet residents safety needs prior to admission.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy King	Administrator	11/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Resident #1 was admitted to the facility on Saturday, September 11, 2010, at approximately 3:00 p.m. Resident #1 had a previous admission to the facility from July 5, 2010 until July 24, 2010, for rehabilitation of a fractured left hip as the result of a fall at home. An interview with the Administrator on October 28, 2010, at 4:45 p.m., revealed resident #1's spouse had contacted the facility requesting the resident be re-admitted to the facility due to the spouse's declining health and resident #1's increased falls at home. A review of resident #1's admitting physician orders dated September 11, 2010, revealed the resident had significant cognitive and functional decline with multiple falls at home. According to the Administrator in the interview on October 28, 2010, at 4:45 p.m., resident #1's admission was discussed in the "morning meeting" on Friday, September 10, 2010. The Administrator stated resident #1's risk of falls was discussed, but was based on the facility's familiarity of the resident from the resident's previous admission. The Administrator revealed that during the meeting on September 10, 2010, no comprehensive information gathering had been conducted with the family, or interdisciplinary meetings conducted, to determine if resident #1's care needs had changed, or if the facility was capable of maintaining the resident's safety. The Administrator explained all new admissions to the facility were placed on 30-minute checks for 24 hours, which was determined, in the meeting, to be adequate to ensure resident #1's safety. The Administrator stated during resident #1's admission in July 2010 the resident's family had stayed continually with the resident, and no behavioral problems or falls had occurred.	F 323	Interventions will be put into place before resident arrives at center. Director of Nursing and/or Director of Education and Training will re-educate nursing staff regarding fall policy which includes fall assessment procedure, appropriate individualized interventions, identify residents that are at an increased risk for falls, use of alarms and reporting change in condition that may increase fall risk to Administrator and/or Director of Nursing (such as agitation, change in orientation that may warrant increased supervision) by 11/30/2010. Starting November 15, 2010 all new admissions will be reviewed in daily clinical meeting (Director of Nursing, Unit Manager, Social Service Director, Nutritional Services Manger, Life Enrichment Director) at the next scheduled meeting after admission to review fall assessment, care plans, root cause of fall risk, ensure appropriate individualized interventions and other issues that may cause resident to have any accident and incident per policy. All new employees will be educated regarding fall policy and procedure, screening process to identify fall risk factors and	

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F 323	Continued From page 2 A review of a facility staffing form dated September 11-12, 2010, revealed on the 11:00 p.m. to 7:00 a.m. shift resident #1's unit was staffed with one RN and two Certified Nursing Assistants (CNAs). An interview was conducted on October 28, 2010, at 3:00 p.m., with CNA #1, who was caring for resident #1 on the 11:00 p.m. to 7:00 a.m. shift on September 11-12, 2010. The CNA stated resident #1 was at the nurses' station in a geri-chair when he/she arrived for work on September 11, 2010, for reportedly being agitated and continually attempting to get out of the bed/chair. CNA #1 recalled RN #1 directing the CNAs to "watch" resident #1, however, no special assignment or arrangements were made to facilitate "watching" the resident, and the CNAs continued to be responsible for the care of the other residents on the unit (approximately 40 residents). CNA #1 stated the nurse provided no other instructions or interventions to be utilized to prevent resident #1 from attempting to get up unassisted or ensuring the resident remained safe. CNA #1 stated at approximately 2:20 a.m. on September 12, 2010, CNA #2 went on lunch break, and CNA #1 was providing care to another resident in their room when RN #1 alerted him/her that resident #1 had sustained a fall. According to the CNA, he/she was unable to visualize resident #1 or hear the resident's alarm sounding prior to the incident. A review of a written statement signed by CNA #2 dated September 13, 2010, revealed CNA #2 was on lunch break when the incident occurred. Interviews were conducted on October 28, 2010, at 2:45 p.m. and 4:15 p.m., with Registered Nurse (RN) #1, who cared for resident #1 on the 7:00 p.m. to 7:00 a.m. shift on September 11-12, 2010.	F 323	notifying the Administrator and/or Director of Nursing regarding a change in condition that may increase fall risk, use of alarms and fall care plan and Nursing Assistant assignment sheets beginning the week of 11/30/2010, Director of Nursing will track and trend all accidents/incidents per policy monthly beginning November 2010. RDCS to audit at least fifty(50%)percent of all new admissions bi-monthly for 2 months beginning week of 11/30/2010 to ensure fall risk was assessed prior to admission and that appropriate interventions were put into place and will audit at least 5 falls monthly that occur for existing residents to ensure appropriate, individualized interventions are in place based on root cause.	

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F 323	Continued From page 3 RN #1 stated when resident #1's family left the facility at approximately 9:30 p.m. on September 11, 2010, "that is when all the trouble started," explaining resident #1 became upset, agitated, and confused. RN #1 recounted how resident #1 was "restless and couldn't keep [him/her] in the bed or a chair." Further interview with RN #1 and a review of nurse's notes for resident #1 dated October 10, 2010, at 10:30 p.m., revealed resident #1 had gotten out of bed unassisted, and became physically aggressive when staff attempted to assist the resident back to bed. Resident #1's physician was contacted and an order obtained to administer resident #1 Haldol by mouth. RN #1 stated the medication was administered, and resident #1 was placed at the nurses' station in a reclined geri-chair with a sensor pad alarm. However, RN #1 stated no provisions were made to ensure staff could visualize resident #1 or hear the resident's alarm sounding at all times, despite the resident's continued agitation, verbalizations of going home, and attempts to get out of the chair unassisted. Further interview with RN #1 on October 28, 2010, at 2:45 p.m. and 4:15 p.m., and review of a facility investigation (undated) revealed at 2:00 a.m. on September 11, 2010, resident #1 remained at the nurses' station in the geri-chair "talking some," when RN #1 went into the medication room, leaving resident #1 unattended. RN #1 voiced being aware CNA #2 was off the floor for break at that time, leaving CNA #1 to care for all residents on the unit, including resident #1, but stated resident #1 had "calmed down and I didn't think [resident #1] would try to get up." RN #1 went on to explain that upon exiting the	F 323	3. All audit findings to be presented to Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review and revision of plan if needed weekly for 4 weeks and bi monthly for next 4 weeks beginning 11/22/2010. 4. Date of Compliance 12/3/2010.	

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F 323	Continued From page 4 medication room at approximately 2:20 a.m., the sensor pad alarm in the geri-chair at the nurses' station was sounding, and resident #1 was found approximately 25 feet from the nurses' station on the floor with a laceration to the back of the head and complaining of right leg pain. Further review of resident #1's nurse's notes dated September 12, 2010, at 5:45 a.m., and an Accident/Incident report dated September 12, 2010, revealed the resident was admitted to the hospital with a laceration of the head requiring four staples, and a right hip fracture.	F 323		